No. 14627

In the United States Court of Appeals for the Ninth Circuit

UNITED STATES OF AMERICA,
Appellant,

vs.

AMOS R. MORIN,
Appellee.

APPELLEE'S BRIEF

On Appeal from the United States District Court
for the District of Oregon

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STATEMENT OF FACTS

Appellee regrets he cannot adopt the Statement of Facts in Appellant's brief; but because of omissions and inaccuracies it is felt necessary to briefly outline the story with transcript reference. No attempt will be made at this time to put specific facts in dispute as this is more properly done in argument; particularly so in this case where the main point for appellate review is a question of fact which will call for specific reference to the evidence and testimony. Because of this, the Court is respectfully asked not to take

our failure to specifically refute any particular part of appellant's Statement of Facts as an acquiescence in the truth of that particular fact; but to bear in mind that we have attempted to accurately state the pertinent facts excluding the unnecessary and immaterial.

Appellee, plaintiff below, was a seaman employed on a dredge by the U. S. Army Engineers and as such was entitled to hospitalization and treatment under the care of the Public Health Service even though his injury or disease might arise while he was off duty. Appellee carried Blue Cross Insurance that entitled him to certain hospitalization benefits; and as a veteran would be entitled to admission to a Veteran's Administration Agency if facilities for his treatment were available.

Between noon and 12:30 P.M. on June 10, 1952 Appellee fell from a ladder at his home in Portland, and in falling caught his left leg between the rungs. (Tr. 45) He was found by his children lying on the ground with his leg still entangled in the ladder. (Tr. 33-34) There was blood all over his stocking and the bone was protruding out about two to two-and-one-half inches. The white of the bone was clearling visible, and it appeared to have ripped right out through the leg. (Tr. 34) The skin was badly torn. (Tr. 43) A neighborhood doctor came immediately and administered a sedative and noted his treatment on a tape which was placed on the patient's forehead.

The patient was taken immediately to the Physicians and Surgeons Hospital in Portland, Oregon. This was at his request and instruction. He arrived there shortly after 1:00 P.M. (Tr. 136 and 218) and was complaining about pain. The testimony of appellee was that he was in great pain in back and leg, but that the pain was mostly in his leg. (Tr. 163) On arrival he was told that they would have to cut his trousers to which he acquiesced. This was in the emergency room in the presence of a doctor .(Tr. 164)

Dr. Constantine Otto Schneider who was taking his residency at Physicians & Surgeons Hospital, was the only medical man who saw the patient on arrival. It was his duty to render initial emergency care and to immediately notify the staff doctor who was to have charge of the patient; and, if instructed by the staff doctor, to go forward with further treatment. In lieu of such instructions his responsibility ended. (Tr. 123) His initial emergency care consisted of examining the wound and he then washed it with a sterile saline solution. (Tr. 83) and cleansed it until it was fairly clean and then applied a compression dressing and possibly a light yucca board splint, (Tr. 79, 80) and then sent the patient to x-ray. (Tr. 80) The cleansing of the wound was an external one. (Tr. 83 and Ex. 16, p. 24) Dr. Schneider described initial treatment as a superficial cleansing. (Tr. 74) In addition to the foregoing treatment, Dr. Schneider prepared for the possibility of shock by typing his blood and making certain that a supply was ready

for a transfusion in the event the patient went into shock. This is routine procedure in the case of serious fractures.

Dr. Schneider's examination and the x-rays showed that the patient had suffered a simple fracture of the left tibia plus a compound, comminuted fracture of the left tibia, a compound fracture of the left fibula, and also a compression fracture of one of the lumbar vertebrae. (Tr. 97) The skin of the leg had two openings in it, one an inch-and-a-half long and the other about an inch long and also an abraded area. (Tr. 95)

Dr. Schneider then notified Dr. Lee A. Craig of the Public Health Service and was told to consult with Dr. John B. Leonard, one of their consulting doctors. He did so and was given no further instructions. Dr. Schneider's responsibility as a resident thus ended; although he personally felt that the patient's condition at this time indicated immediate emergency care which might necessitate going to surgery. However, since the staff doctors had come into the case by telephone consultation, Dr. Schneider had neither responsibility nor authority to see to it that such further emergency care was given. (Tr. 113)

Dr. Craig did not see the patient at all on June 10. (Tr. 138) He first saw him on the morning of the 11th of June, at least twenty hours after the accident. He did not look at the wound. (Tr. 140-141) Dr. Leonard, the other responsible staff member, first saw the patient about the same

time as Dr. Craig, on June 11th, in making his rounds; but he has no independent recollection of the case and the record discloses that the bandage applied by Dr. Schneider was not disturbed and he, too, did not look at the wound. (Tr. 297, Tr. 114, Pl. Ex. 1) The only Portland doctor who looked at the wound was Dr. Schneider.

Drs. Craig, Leonard and Morrison, the latter the chief Public Health doctor at Portland, between them decided that it was safe to send the patient to Seattle and have the necessary surgery performed there. The first consultation had between Drs. Craig and Leonard was about 11:30 A.M. on June 11. (Tr. 144, 145) It was finally decided for reasons of economy to send the patient to the Marine Hospital in Seattle. (Tr. 51; Tr. 344) He was sent to Seattle by ambulance at 8:00 A.M. June 12 and arrived about noon the same day, approximately 48 hours after he was injured. (Tr. 149)

The patient was comatose on arrival at Seattle. The wounds in the leg were infected. (Ex. 3, p. 9) The hospital records show in addition that the wounds after the ambulance trips were respectively 12 centimeters (approx. 5 inches) and 5 centimeters (approx. 2 inches) in length. It is only fair to say that Dr. King testified that the wounds were not this large. The x-ray comparison showed an increase in displacement of the bones. (Tr. 279) The patient had bruises on his head and arms. (Tr. 56) He was imme-

diately taken to surgery and the wounds cleaned, debrided, the fractures reduced and the wounds closed, and the patient placed in a body cast. Later, on July 11, 1952, the surgeons at the Marine hospital, in surgery under aseptic conditions, inserted an Eggers Plate in the left tibia. After approximately one month's further treatment the patient felt his progress was still unsatisfactory and he decided to leave the Seattle hospital and to return to Portland to obtain orthopedic care. He left Seattle August 13, 1952. (Tr. 175) In the Seattle Hospital he was operated on by a General Surgeon and not by an Orthopedic Surgeon.

The history of the patient's treatment in Seattle shows the results of the poor care in Portland. The nurse (Tr. 55) and a Dr. Brown, a Public Health doctor, (Tr. 166) both expressed amazement at the type of treatment the patient received in Portland. Dr. Tucker, Assistant Surgeon at the Marine Hospital in Seattle, the first person to see appellee on arrival at that institution, on examination found the wounds in the leg to be infected (Ex. 3, p. 9) Dr. Tucker stated that the patient arrived in poor condition with exposed bone showing in compound tibial fracture, was bleeding and smelled very badly. (Ex. 3, p. 18) During treatment Dr. Charles Keever, an intern at the Marine Hospital, noted that there was infection of the bone (Tr. 329, Ex. 3, Progress Notes 7-24-52); but it is only fair to state that Dr. Walker took issue with this finding relying on the hearsay statement of a pathologist who did not testify.

On return to Portland the family doctor, Dr. Thorup, came to the home of appellee, examined the wound through the window in the cast, and he immediately administered penicillin. This was August 14, 1952. (Tr. 176) Dr. Thorup called in Dr. Cherry, a leading Portland Orthopedist, who commenced treatment immediately. Unfortunately, Dr. Thorup was not available for testimony as he was in Europe during the trial of this case. Dr. Cherry first saw the appellee on August 24th; and during the ten day interim penicillin was administered to him every day by Dr. Thorup's nurse.

On August 25th Drs. Cherry and Thorup did a closed manipulation of the leg under anesthesia (Tr. 177) The bone had not yet set and was angulated. (Tr. 205) At this time Dr. Cherry testified there was infection present in the bone. (Tr. 206) The wounds were draining and the skin was unhealthy. The condition was described as locally critical. (Tr. 210) This description was defined as meaning that there was question whether the situation would or would not heal because of the infection. (Tr. 210, 211) There was pus present. (Tr. 260) The infection was described as a latent infection that could flare up at any time. (Tr. 260) The patient was in a private hospital until August 28th, and under observation and treatment by Dr. Cherry for several months during which time the wound site condition continued to deteriorate until January 24, 1953 when he was rehospitalized by Dr. Cherry. (Tr. 207) This hospitalization was for the removal of the Eggers plate, in

surgery under aseptic conditions, the plate having served its purpose in stabilizing the bone shaft to permit union of the fragments, but was now an irritating foreign substance that was aggravating the infected condition of the bone and the drainage out through the open wound site. During this period appellee was able to go back to work as his superior gave him light work .(Tr. 178)

Subsequent to the second hospitalization under Dr. Cherry's supervision the appellee made application to enter the Veteran's Hospital in Portland where he was treated by Dr. Davis, one of the doctors associated in Dr. Cherry's office. During his period in the Veteran's Hospital the patient was visited by Dr. Cherry although he was not a member of the staff of that institution. In the course of the confinement in the Veteran's Hospital, many operations were performed on the leg, including the grafting of skin from one leg to the other, which required a long period of immobilization of the patient in a cross-legged cast. One of these periods lasted as long as six weeks. (Tr. 182) In all the patient had fifteen different skin grafts. (Tr. 183 and Ex. 10, Reg. No. 89738 and Reg. No. 87273, U. S. Vets. Hosp.) He has had flesh removed for grafting on the left leg, from his right leg, left thigh, and other parts of his body and still has a residual tenderness in some of the places from which skin was grafted. (Tr. 182) The leg was still draining at the time of the trial (Tr. 184), and it will probably continue to drain and give trouble. (Tr. 249) He has

and will have a deformed leg and osteomyelitis which tends to recur, pain and tenderness in the ankle which will improve.

The Court entered judgment for $45,000 general damages and $4,711 special damages.

ANSWER TO POINTS 1 AND 3

The District Court did not err in finding that the appellant failed to render immediate, adequate and proper medical and surgical treatment.

ARGUMENT

I.

The first portion of the argument in appellant's brief is in support of points 1 and 3 of their assignment of errors which points are as follows:

"1. The evidence in the case fails to establish that there was any deficiency in the treatment accorded appellee in the Physicians and Surgeons Hospital at Portland, Oregon". "3. The Court erred in finding that appellant in treating appellee did so in a negligent, careless manner proximately causing injuries to appellee, by failing to render appellee immediate adequate and proper medical and surgical treatment, cleanse, debridement and closure of the wounds at the site of the fracture of the left tibia."

By these assignments of error, appellant has claimed that the finding of fact by the Court below was not supported by any evidence. As is well established, the finding of fact is binding on the appellate Court unless the Court can affirmatively say that there is no substantial evidence to support the finding; and, therefore, in arguing this point it is only necessary for appellee to show proper evidence in support of the finding and not incumbent upon us to show that the finding was correct, although we think the same was clearly the only finding that could be made on the evidence.

In order to organize the answering argument to the points raised by appellee in this portion of his brief, we will review the evidence regarding the different problems which we think are involved in the case and questioned in appellant's brief. We will attempt in this review to get a whole picture and refer the Court to the pertinent testimony in the transcript rather than quote out of context certain isolated answers as was done by appellant. We will, however, quote portions sustaining the verdict found below when we deem it necessary so to do.

A. Condition of Left Leg After Fall and Upon Arrival at Physicians and Surgeons Hospital.

The evidence clearly shows that the left leg was suffering from severe fractures. There were two compound fractures, one of the tibia and one of the fibula, each of which tore through the skin and caused profuse bleeding, and

created the entry points for the present infectious condition of the appellee's tibia. Four persons testified as to the condition of the leg immediately after the fall. David Morin, plaintiff's son, described it as follows:

> "A. It was his left leg. There was blood all over his stocking and the bone was protruding out about two inches or about two and a half inches. You could see the white of the bone very clearly. It looked like it had been ripped right out through his leg. There was blood all over his stocking and his pants were bloody, so you could see it." (Tr. 33, 34)

Dale Morin, another son, testified as follows:

> "A. Yes, I looked at it. You could see the bone was broken and it was sticking out of the leg about two and a half inches.
>
> Q. Can you show us on your leg which side of the leg the bone was sticking out?
>
> A. The bone was sticking out on this side of the leg.
>
> Q. You are pointing to the outside?
>
> A. Yes.
>
> Q. Can you tell us what it looked like?
>
> A. A big gash and quite a bit of blood and bone was sticking out about two and a half inches.
>
> Q. Do you have any idea of the size of the gash or cut?
>
> A. It was about two and a half or three inches long." (Tr. 40)

Mrs. Shirley Cannard, plaintiff's daughter, testified as follows:

> ". . . his leg was bent in over a rung of the ladder and at the time he was lying more or less on his right side, and the bone was sticking out and there was blood all over and the skin was all torn where it came through because the bone was pointed . . ." (Tr. 45)

and Amos R. Morin, the appellee herein, testified, (Tr. 161) that he could see the bone was sticking out himself as he lay on the ground after the fall.

The x-ray films of Morin's left tibia and fibula taken on June 10th, 1952 soon after Morin's arrival at Physicians and Surgeons Hospital, were interpreted by Dr. Cherry (Tr. 213, 214) as showing a complete irregular fracture that is completely offset.

The line of soft tissue, muscle, fat and skin was visible in the x-ray and from the x-ray reading it appeared that the bone fragment was completely outside of the skin. The diagnosis from the reading was fracture of the fibula and tibia, compound with *severe* displacement. (Tr. 214, Ex. 2 A and 2 B.)

Dr. Schneider was the only physician in attendance at Physicians and Surgeons Hospital who took the trouble to see the wound to the left lower leg. Drs. Craig, Leonard and Morrison (Tr. 343) did not look at the wound site. (Ex. 15, p. 16 and Tr. 309) Dr. Craig has no independent

recollection of whether he was informed that the fracture was compound. (Tr. 133)

No recorded description of the wound exists in the Portland hospital records and the responsible attending physicians in that city, in addition to not seeing the wound, are not certain that they were informed of its extent or nature. (Tr. 135, Dr. Craig) Dr. Leonard does not remember what happened and testified only from what he was told. (Tr. 309)

While the Portland record does not describe the wound, the Seattle U. S. Public Health Service hospital Record (Ex. 3) in the narrative summary describes the laceration to the left shin as "approximately 12 cm. long and 4 cm. wide . . . with proximal bone fragment out through the wound". The clinical record signed by A. Tucker, Assistant Surgeon, dated June 14th, 1952, gives the same description (Ex. 3, p. 9) and in the operation report from the Seattle hospital, the wound is described as a coarse laceration in two parts, one about one and one-half inches long and the other an inch long with the bone visible through the skin.

Dr. Cherry, in comparing the condition in Portland with that on arrival at Seattle, states there was more displacement of bone and damage to soft tissue. (Tr. 279, 280)

Thus, there is no question but there was a severe and dangerous laceration of the skin of the left tibia caused by and aggravated by a double compound fracture. The skin

was not merely punctured, it was torn, bleeding and the bones were exposed. The initial damage was great. The subsequent tearing and aggravation caused by the trip of some 200 miles by ambulance from Portland to Seattle and the delay thereof added to the immediate seriousness and subsequent injuries to these wounds and the infection of the bones adjacent to them.

B. Treatment in Portland June 10th, 11th and 12th, 1952 at Physicians and Surgeons Hospital Was Not Proper and Constituted Malpractice.

Appellee was not properly treated in appellant's hospital facility in Portland. His condition required immediate care by a competent surgeon. The need for immediate and adequate care is printed out in Plaintiff's Exhibit 14, page 58, *Pictorial Handbook of Fracture Treatment:*

> "A compound fracture constitutes one of the most serious of all emergencies. The involved bone is exposed through the skin and must be considered to be potentially infected. The need for prompt and adequate surgical care is as urgent as that for the treatment of acute appendicitis, a ruptured spleen or perforation of a peptic ulcer. Delay in treatment of a compound fracture may result in infection, with osteomyelitis, septicemia, non-union, prolonged invalidism, loss of a limb or death."

Instead appellee received a form of First Aid which is best described by Dr. Schneider, the trainee resident at Physicians and Surgeons Hospital, as:

> ". . . my treatment was confined to an emergency. It would be necessary in emergency to give the same sort of treatment *that anyone who sees a man with a fractured leg would be entitled* to give." (Tr. 85) (Italics added)

Dr. Schneider acknowledged his lack of competency to give the imperative treatment required. His authority and right to continue treating also ceased when the staff doctor, Dr. Craig, failed to further instruct him. Unfortunately, Dr. Craig and his consultant, Dr. Leonard, only relieved Dr. Schneider of responsibility. They failed to take it on themselves and in effect did nothing. Thus Morin was without effective care from early afternoon of June 10 to the morning of June 11—and thereafter until June 12 in Seattle. The first eight hours after injury on June 10 was the "golden" period of treatment as plaintiff's expert, Dr. Cherry, described it; but Drs. Craig and Leonard did not bother to come near the hospital or even let Dr. Schneider, admittedly not qualified, give any further help. And when, twenty hours late, they deigned to see the patient, the so-called qualified men did not even look at the wound.

We respectfully submit the treatment was not only inadequate, it was virtually non-existent.

In addition to the foregoing quotation of basic medical principles, we have the following evidence as to proper treatment. Dr. Cherry testified:

> "The proper treatment, in my opinion—and I believe it is shared now universally—is that this wound should be very carefully examined, carefully cleaned, to its depth, reduced if possible and the wound closed. If there is any foreign material anywhere, it should be removed, if there is devitalized tissue anywhere it should be removed." (Tr. 240, 241.)

The summary of the operation at the United States Marine Hospital in Seattle, June 12, 1952 at 3:03 P.M. (Tr. 95) describing the procedure followed within three hours of Morin's arrival in Seattle was the same procedure as that described by Dr. Cherry in his statement of what constituted proper practice in this case. Dr. Cherry defined the negligence of the appellant in his testimony (Tr. 245, 246) as being the failure to give the treatment he indicated as the proper and universally accepted treatment within the period of five or six hours after the injury. (Tr. 245, 246) The only thing wrong with the treatment eventually received was that it was several days too late.

In addition, Dr. Cherry testified:

> "I would say if there had been only one gross error in his treatment, I would say the lack of adequate immediate care, nothing else, is of enough significance to be of extreme importance to me. I think there may have been a little more judgment used in some of the other things, but it does not compare in what is going to happen to this man over the months and years ahead, does not compare to this one error of not getting adequate care early." (Tr. 245)

All that Dr. Schneider stated was done by him, the only physician in Portland who treated the wound, was:

> "Q. You have testified you externally cleansed the wound with this sterile saline solution, and that you then bandaged the wound and, to your recollection you applied a splint. Is that a fair statement of what you did?
>
> "A. That is correct, except I am not positive that I applied the splint at that time or after the X-rays were taken, but I am sure I applied a splint to that man. That is customary." (Tr. 92, 43)

Dr. Schneider's idea of the adequacy of the treatment is set forth as follows:

> "Well, you mean my right to carry on treatment? Well, certainly, my treatment was confined to an emergency. It would be necessary in an emergency to give the same sort of treatment that anyone who sees a man with a fractured leg would be entitled to give." (Tr. 85)

He was obviously embarrassed despite his lack of professional responsibility.

Even Dr. Leonard's idea of proper treatment contradicts appellant's contention as he required internal irrigation of the wound-site. (Tr. 308) A surface or external cleansing of the wound was not adequate and in order to adequately clean this wound the patient would have to be in surgery and under an anesthetic. (Tr. 268)

Knowing that there was a gross failure to render the needed care, an attempt was made to excuse the same because of shock and ileus. There is no evidence that Drs. Crag or Leonard were told of shock or ileus for a very salient reason: these were not problems. They are afterthoughts and lame excuses.

Appellant contends that the initial treatment in Portland was proper and tries to justify the failure to give the surgical treatment within the time indicated by Dr. Cherry by emphasizing the possibility of shock. The record does not disclose any justification for this. Dr. Schneider characterized paintiff's condition as "incipient shock". (Tr. 79) While cross-matching of blood for transfusion was made no blood was ever given. (Tr. 89) This was done simply in anticipation of the possibility of shock. Dr. Schneider mentioned "incipient shock" in answer to a question whether the patient ever was in actual shock, (Tr. 91) and stated that he never was in *actual or complete shock.* (Tr. 121).

Dr. Craig, when asked: "From your observation of the patient, not from what you were told, would you say the patient was in shock", replied, "No." (Tr. 143).

Dr. Cherry stated that all fracture cases are in incipient shock but this is not serious. It may need no correction and is always met by a blood transfusion. This is not an extraordinary condition. In this case he states there was no treatment for shock. (Tr. 223)

Nobody was interested enough during this period to order the taking of frequent blood pressures which would usually be taken if any real fear of shock existed. (Tr. 226, 227, Tr. 142, 143) Where there is fear of shock the blood pressure is taken every half hour. (Tr. 227) The only indication revealed by the Portland record (Ex. 1) relating to a condition of shock was the cross-matching of blood explained above and this is routine in fracture cases.

Very evidently the element of shock as a deterrent to prompt and adequate surgical treatment within the golden time in the treatment of compound fractures of from six to eight hours after injury, (Tr. 241) did not exist as a sufficient factor at the time of the Portland hospitalization to prevent the giving of the needed treatment for Morin's condition.

The same can be said for ileus, which is described as loss or relaxation of the bowels, bladder and organs of that type. (Tr. 92) Its onset was said to be shown by the need for catheterization at about 10:30 P.M. on the 10th of June. Its presence would not be anticipated in a fractured back usually until about 24 hours. (Tr. 231) The fact that on the morning of June 11th at 6:00 o'clock Morin was able to have "a light diet and ate fair" indicates he did not have an ileus or shock and that he was cooperative at that time and able to eat. (Tr. 232)

All Morin received was first aid. This was not Dr. Schneider's responsibility or fault. It rested with Drs. Craig and Leonard, the Public Health Service doctors who were not interested enough to see the patient when it was important or even give instructions. This was inexcusable and gross inattention. (Memorandum Opinion, Tr. 22)

The surgical treatment given in Seattle on June 12, 1952, which is the treatment that Morin insists should have been rendered to him within the first six to eight hours of his stay at the Physicians and Surgeons Hospital in Portland, Oregon, is described in Exhibit 3 in the operation report and in the transcript. (Tr. 95).

After reviewing the entire hospital record at Physicians and Surgeons Hospital, in the course of his testimony and upon being questioned as to whether Morin was properly treated during his course of hospitalization in Portland, Dr. Cherry testified as follows:

> "A. Any compound fracture is an immediate emergency, and anybody who ever went through medical school should know it. We spend hours and hours trying to teach everybody that point. This is a compound fracture and it is a severe thing and it involves an area where there is notoriously poor healing, and if any compound fracture is an emergency this would be a great emergency.
>
> The proper treatment, in my opinion—and I believe it is shared now universally—is that this wound

should be very carefully examined, carefully cleaned, to its depth, reduced if possible and the wound closed. If there is any foreign material anywhere, it should be removed. If there is devitalized tissue anywhere, it should be removed.

The time element is of extreme importance. We figure that what we call the golden time in the treatment of fractures, compound fractures, is from six to eight hours.

If we get a fracture at 3:00 o'clock in the morning, we get out of bed and we come and call the surgeon and anesthetist and x-ray technicians, everybody—it takes about ten people—and that fracture is treated just as soon as we can do it, in order that we can treat this patient properly, because when contamination gets in there, you get danger of infection and of impaired healing, and we figure that the time is from six to eight hours, the earlier the better, but after that length of time the tissue is damaged and cannot heal as well as it could before that.

When it goes 24 hours, ordinarily we would not even close it because there would be danger in closing the wound.

The most striking thing about this whole thing to me is how people practice medicine and don't know that or don't practice it; that is, early, adequate cleaning, reducing and closing and fixation of the compound fracture. You would not expect everybody certainly to be able to do it adequately, but I would expect anybody, a nurse or anybody, if they didn't know how to do it, I would expect them to know what should

be done, and, if they can do it themselves, why, then, go ahead; if not, get some help.

The criticism I have, after carefully studying this, is that, not that they wouldn't know how to do it but that they did not, for some reason, either do it right then or call someone in who knew how to do it."

. . . .

"A. I would say if there had been only one gross error in his treatment, I would say the lack of adequate immediate care, nothing else, is of enough significance to be of extreme importance to me. I think there may have been a little more judgment used in some of the other things, but it does not compare in what is going to happen to this man over the months and years ahead, does not compare to this one error of not getting adequate care early." (Tr. 240-245)

This testimony plainly informed the Court of the deficiency in the treatment afforded Morin in Portland and stated the proper treatment to be given.

Appellant's own expert, Dr. Walker, confirmed the opinion of Dr. Cherry, when questioned by appellant's counsel on the need for immediate treatment:

"Q. But is that something that the general medical profession would, in your opinion, concede, that in these situations each case must be dealt with individually and left to the judgment of those who have seen him and know what his condition is at that time?

A. Yes, if they have competent backgrounds and have competent reasons for their judgment, yes.

Q. I think you have told me that where a man's general condition permits you would like to take him to surgery within six to eight or ten hours?

A. Yes.

Q. The sooner the better?

A. Although that deadline of six hours is pretty arbitrary, a pretty arbitrary deadline. Antibiotics have done wonderful things for surgery in general and fractures in general, as well. I cannot say arbitrarily six hours or five hours, or say that within five or six hours you are not going to get an infection and in six hours and one minute you are. Antibiotics have changed all that. You can see it evident in this particular case." (Tr. 335)

And again, Dr. Richard F. Berg, called as an expert witness by the appellant, upon questioning, clearly indicated that he deemed immediate and prompt treatment to be the proper course of treatment for wounds and injuries of this type.

"Q. You would consider a compound fracture of the lower third of the tibia more or less a serious situation?

A. Yes, I do. I think that compound fractures any place are an emergency.

Q. Isn't that particular portion of the tibia particularly dangerous, when there is a fracture of that type?

A. There are, in any portion of the tibia, either the upper part or the lower third.

Q. Isn't it ordinarily the practice to go in and clean and debride the wound as quickly as possible?

A. According to our teaching and from the books, that is the thing to do, but, as I said, there are instances where your judgment, after evaluating the situation, looking over the situation, sometimes you defer very active or intensive work.

By 'debridement' maybe I mean something else than you do. Debridement is quite an extensive and detailed piece of work. We have to be careful of the nerves and of the blood vessels. Sometimes—

Q. You generally do that right away, don't you?

A. Yes, try to do it right away.

Q. *Ordinarily, if you are called in on a compound fracture of that type, do you wait until the next morning before you visit the patient, if you are called, say, in the afternoon?*

A. *Not ordinarily. I like to do it just as soon as I can.*

Q. You would not wait until 11:00 o'clock the next morning to go over to see the patient, ordinarily?

A. Not unless I was pretty assured he was all right and that he had been taken care of.

Q. What about exposure of the wound?

A. Well, there again we run into two schools of thought. In the early days we would have been very much criticized for closing any open wound. Nowadays we close them because we have antibiotics, although you do not have to necessarily suture them, if

you put some form of dressing on and cleanse them. They are continuously filling in, you know." (Tr. 362-363)

Dr. Berg, appellant's own witness, when questioned by appellant's counsel regarding the treatment given by appellant's physicians in Portland qualified his answer that he found no fault therein by saying,

> "Under the circumstances, I would say, inasmuch as there was no possibility of openly reducing the fracture or continuing the treatment of this man in the present locality, under those circumstances I would see no fault in that at all, in the manner in which it was handled."

It is submitted that there is no evidence in this case showing why Morin could not be treated in this locality and that Physicians and Surgeons Hospital is and was a grade A hospital (Tr. 138) and was equipped and capable of caring for a patient in Morin's condition.

The Court is referred to a complete reading of the excerpts from plaintiff's exhibit No. 13 appearing in the transcript of record (Tr. 375 through 386) which confirms Dr. Cherry's testimony when read totally and not when treated to the piecemeal attention given by appellant. You are referred to the testimony in the transcript where appellant pursued the same use of language out of context as is used in the brief. (Tr. 268, 269, 270)

Dr. Schneider consistently indicated that he did not feel competent or qualified to deal with the treatment of Morin. (Tr. 98, 99, 115)

> "Q. My question is: Would you have preferred to have had a more experienced surgeon with you?
>
> . . . .
>
> A. I believe that would be logical for anyone, sir." (Tr. 98)

And further:

> "Q. Would you have considered it good practice to have taken such a man direct to surgery and given him a general anesthetic, a man that was in that serious condition?
>
> A. I think that someone more specialized in surgery than myself would be more qualified to answer that question." (Tr. 115)

Dr. Berg when questioned with regard to the element of discretion said,

> "A qualified man, I would say, should have a little better insight into it than someone who had not seen the circumstances."

And Dr. Paul Walker, an expert appearing for appellant, when questioned by appellant's counsel in testimony appearing above in this brief (Tr. 335) conditioned the right of a physician to exercise discretion in the circumstances confronting Dr. Schneider by saying that discretion

could only be exercised by those having competent background and having competent reasons for their judgment. (Tr. 335) It is submitted that Dr. Schneider by his own testimony disqualified himself for making the decision.

Thus the only person exercising discretion in treatment was one who by his own admission was not qualified to do so; and, moreover, handicapped because the responsible doctors did not give him further instructions or even see fit to look at the patient the day of the injury or to look at the wound at all at anytime.

ANSWER TO POINTS 2 AND 5

The District Court did not err in rendering a verdict in favor of appellee because there was substituted evidence to support the verdict and to establish that appellant's malpractice was the proximate cause of appellee's damages.

ARGUMENT

We will not here repeat all the incidents that indicated the existence of an infection because of the poor treatment in Portland which have been heretofore pointed out in our Statement of Facts and in our discussion of the previous points. Suffice it to say that everything in the trial of this case points to the fact that upon arrival at Seattle the patient had a latent infection in the wound site. An attempt was

made by counsel for the appellant to insert into the case the possibility that the infection could have started entirely from poor tonsils or sinus infection. The statement by Dr. Leonard, appellant's witness, on page 300 of the transcript indicates that this is a possibility but it doesn't happen too often. Dr. Cherry, a qualified orthopedic surgeon in Multnomah County, Oregon, who is constantly dealing with this particular problem, answered the question regarding this possibility as follows:

> "That is quite an involved question. I can say that there may be theoretically a remote possibility of it occurring at the fracture site. I would also say that I have never known it to occur; I have never seen it and, in my recollection, I have never seen it in the literature, and I would say that possibility is extremely remote, while on the other hand you have a very obvious reason why it would occur in a compound fracture." (Tr. 250)

The obvious reason referred to is the failure to treat the patient in the golden six or eight hour period immediately after the accident.

It is important that the emphasis on the question of osteomyelitis and infection does not blind the Court to the fact that there were other consequences of the negligence of appellant that caused damage to Morin. Some of these other consequences were poor union of the bone, poor healing and impairment of circulation in the leg, damage to the skin and general prolongation of treatment, numerous

additional surgical operations and the pain and suffering that accompanied this prolongation and further operations together with the residual pain and suffering which the patient is now enduring.

We state quite emphatically that rather than this question of proximate cause being a matter of doubt and that we have failed to support the same by any evidence, that we feel that there was no other conclusion that could be drawn from the evidence and facts introduced at the trial but that all the probabilities point to the fact that the failure to give the proper treatment in Portland and the sending of the patient by ambulance, under the conditions recited in the transcript, to Seattle was the cause of the infection, the failure to heal of this wound and the failure of the bones to unite and the numerous surgical procedures that were necessary because of this negligence.

Dr. Cherry's testimony is unequivocal as to the cause of the infection and the other consequences just above enumerated. Dr. Cherry is backed up in his opinion by the texts which warn that treatment must be prompt in order to avoid the varying consequences that here followed because of the negligence of the appellant. Appellant by bringing up a remote possibility attempts to shake the opinion expressed by Dr. Cherry and backed up by medical thought and practice. However, Dr. Cherry in answer to these questions, while admitting it is always possible for almost anything

to happen, states that in his opinion cause of this condition was the poor treatment in Portland.

Coupled with Dr. Cherry's opinion, you have the eloquent evidence of the admission record at the Marine Hospital showing that the wound was infected, the several comments of the personnel of that hospital regarding the poor Portland treatment and the fact that Dr. Thorup gave penicillin immediately upon seeing the patient on his return to Portland and Dr. Cherry found the limb to be infected on his first examination. All of these things show that the wound was infected in Portland and that the trouble that was had in Seattle and subsequently, was a direct result of the inattention and inexcusable neglect of the Public Health Service in Portland.

As quoted in the case of *Ronner v. Bekin's Moving Company,* 125 Or. 280 at 287, 266 P. 627, there is in this case the same situation:

> "There is a logical chain of circumstances leading up from the injury to the death, and an apparently competent expert is practically positive that the death was the result of injuries, which other testimony tends to indicate, were inflicted by the negligence of the defendant's employee."

The chain in the instant case is complete and points directly to the damage that resulted.

This is not a case of a speculative verdict. An able and experienced trial judge who has examined the records and listened to the testimony, drew the only conclusion that could be drawn from the evidence: that gross neglect in Portland caused an infection and the failure of healing of the wound and leg of Morin and the trial Court's decision is well supported by much evidence. Indeed a finding to the contrary would be reversible error if we were appealing from such a finding.

Appellant quotes language from the case of *Lehman v. Knott,* 100 Or. 59, 71, 196 P. 476 regarding the distinction between improper treatment and negligent treatment. (Tr. 49) This particular language of the Oregon court in *Lehman v. Knott,* supra, was considered and explained in the case of *Malila v. Meacham,* 187 Or. 330, 334, 335, 211 P. 2d 747, where the question raised by appellant in his brief at page 49 is fully answered. Appellee depended upon the language of the *Malila* case, a case in which one of Morin's counsel represented the plaintiff, in guiding the choice of questions asked of Dr. Cherry. The language appearing in appellant's brief at page 49 was cited to the Court in the *Malila* case to substantiate the defendant's contention there that it was error to ask this question: "Assuming that those facts did exist, would you say it was proper practice to extract a tooth under those conditions?" Saying that it was difficult to perceive the relevancy of the language quoted on

page 49 of appellant's brief to the issues before the Court in *Lehman v. Knott,* the Oregon court said:

> "In a malpractice case the question whether a physician has in a given case adopted the proper treatment is one in which the opinions of medical men may be received in evidence and they may state whether in their opinion the treatment was proper or not, whether it was in conformity with the rules and practice of the profession."

The court then says:

> ". . . Counsel for the plaintiff should have the right to rely on these pronouncements of this court, and they should be adhered to unless the rule they announce is demonstrated to be unsound or likely to bring about miscarriage of justice. Neither of these things, in our opinion is true." *Malila v. Meachem* (supra at 334, 355).

The statement extracted from *Lehman v. Knott* by appellant was discredited by the Oregon court and the *Malila* case fully answers appellant's inquiry. It is stated clearly in the *Malila* case, "The question, therefore, is whether an opinion of a qualified medical expert that a given treatment was not proper does, in substance, constitute evidence of such fault. We think that it should be so held." (idem., p. 336)

In view of the fact that Dr. Cherry was a treating physician of Morin, and by personal knowledge and observa-

tion was familiar with facts upon which his conclusion was based a hypothetical question was not necessary to permit the admission of his opinion with regard to the propriety of the treatment given and the result of the failure to give proper treatment. (Tr. 244, 267) *Foot v. Lindstrom & Feigenson,* 143 Or. 309, 312 (22 P. 2d 321); *Carnine v. Tibbetts,* 158 Or. 21, 38 (74 P. 2d 974). The *Foote* case is quoted in the *Carnine* case at p. 38:

> "Where an expert witness, by personal knowledge and observation, is familiar with the facts on which his conclusion is based, and those are the facts which have been testified to in the cause, there is no necessity of supplying the hypothesis."

However, in the abundance of caution and to fully present the evidence in this case, in addition to asking a direct question of the doctor, a resume of the evidence regarding the patient's condition and the treatment given was made and this took a hypothetical form. The appellant, by interrupting the course of questioning, added elements of fact which he deemed essential to the question. It is clear that Dr. Cherry's answer was based upon all of the facts in the case. ". . . but to the question Mr. Ryan asked, including all the other statements made, I still have to say that the treatment was not correct; it was not what should have obtained . . ." (Tr. 245)

There can be no doubt as to the treatment meant by Dr. Cherry in his answer stating "that the treatment was

not correct . . ." (Tr. 245). The testimony as given shows that this could only refer to the act of malpractice which the witness had just defined, that is, the improper treatment in Portland. This was undoubtedly understood by all concerned and was not misleading. See in this regard *Carnine v. Tibbets,* supra, at p. 37.

The cases above cited guided counsel in the trial of the case and testimony was well within the rules therein annunciated.

ANSWER TO POINT 4

The Court did not err in finding that the appellant, in treating appellee, failed to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon, and like communities in the treatment of the comminuted compound fracture of the left tibia.

ARGUMENT

Appellee's argument in support of Point IV of its assignment of error is repetitious. Previously in this brief, it is felt that it has been amply demonstrated that there was malpractice and that the treatment afforded Morin in Portland was not proper practice; and that appellant failed to exercise the degree of care and skill ordinarily exercised by physicians in Portland, Oregon and like communities in similar cases.

Drs. Cherry, Walker and Berg all seem to be in complete concurrence as to the usual and proper treatment to be given a compound fracture such as the one suffered by Morin. Prompt, immediate and adequate care within six to eight hours was the indicated treatment and the experts all agree with each other as to this as a rule of treatment. Previously we have shown that there is no evidence in the record to justify an exception from the rule.

The cases cited by appellant in his argument under Point IV of its assignment of error do not support appellant's contentions. On the contrary, these cases demonstrate that the trier of facts herein properly determined the question of malpractice and proximate cause. For example, in the case of *Malila v. Meacham,* 187 Or. 330, 211 P. 2d 747, where a dentist was held liable for malpractice for the extraction of a tooth in the presence of active trenchmouth, it was held that where there was expert testimony as to the impropriety of the defendant's treatment of the plaintiff, the Court could not say as a matter of law that the defendant was guilty of nothing more than an error of judgment. It held that where there was a difference of opinion among the experts as to the fact, the question should be submitted to the jury. The evidence in the case at bar demonstrates that the treatment given was not proper. Further, that if there was judgment exercised, it was completely lacking in skill, knowledge and diligence with particular emphasis on the failure to give care.

It can hardly be said that skill, knowledge or care has been given to a case of this kind by the attending physicians and the consultant when the evidence clearly shows that they did not visit the patient until at least twenty hours had elapsed after his reception at the hospital and that upon belatedly calling at his bedside, even then failed to examine the wound or take any further steps for his immediate care.

The two cases relied upon by appellant in support of Point IV of its assignment of error, both the *Malila* case and the case of *Moulton v. Huckleberry,* 150 Or. 538, 46 P. 2d 589, resulted in an affirmation of the judgments against defendants. In both of these cases an issue of fact was submitted to the jury as to whether the defendant was negligent in each instance and whether such negligence was the cause of plaintiff's injury. The statement of plaintiff's expert in each case that the care was not proper. made a jury question of this issue.

A further discussion of the argument directed to this part of appellant's brief seems unnecessary in view of the fact that the argument under this assignment of error is substantially the same as the arguments under Points I and III of the assignments of error which we feel we have already demonstrated to be without merit. The cases cited by appellee in answer to that argument and the rules therein apply equally to this and a reiteration of them will serve no purpose.

ANSWER TO POINT 6

The discussions and arguments heretofore set out in answer to appellant's Points One through Five, are herein adopted in toto in answer to appellant's Point Six. No additional argument is therefore deemed necessary.

ANSWER TO POINT 7

The verdict rendered by the District Court was not excessive.

ARGUMENT

The judgment rendered by the experienced and able trial judge in this case was not excessive and fairly took into consideration the age, occupation, pain and suffering of Morin, and the prognosis made by Dr. Cherry. In addition, the negligence of the appellant resulted in a lengthening of days and months of hospitalization, treatment, pain and suffering by Morin. (Tr. 246)

Morin was suffering pain at the time of the trial "it just hurts, throbs and pains real deep". (Tr. 184) He suffers from fatigue and weakness in his ankle and left leg. He is no longer able to engage in his usual sports and activities.

(Tr. 186) A total of 15 skin grafts, in addition to other surgery, have been performed in an attempt to remedy the present infection and drainage in his leg. (Tr. 183) (Exhibit 10, Record of operation performed during hospitalization in the United States Veterans' Hospital; Registration numbers 87273 and 89738.)

A review of comparative judgments and verdicts is not deemed necessary in view of the available literature thereon. Morin in suffering from osteomyelitis which is a condition resulting in sloughing of the bone necessitating frequent operations to keep ahead of it. This condition can result in amputation of the whole limb. (Tr. 301) It is a recurrent disease with painful and disfiguring effects upon the injured leg. (Tr. 249)

The many skin grafts and operations, the long periods of hospitalization, with particular reference to the hospitalization in the United States Veterans Hospital which is detailed in Exhibit 10, not only shows the course of treatment, but reflects the suffering, inconvenience, fear and misery, with attendant financial loss, faced by this formerly active and healthy man. It is submitted that the evidence amply supports the judgment as given and that while the judgment is adequate it is conservative in the light of the past suffering and obvious future difficulty faced by the appellee.

ANSWER TO POINT 8

The Court did not err in finding that the appellee would be required to undergo further operations.

ARGUMENT

The arguments and review of the evidence supporting the judgment of the court in the amount given adequately refutes this contention of the appellant and we feel that further argument directed toward this assignment of error is unnecessary. It is sufficient to indicate that in the language of R. M. Berg, M.D., appellant's own witness, the condition was characterized as "a chronic osteomyelitic process". (Tr. 394). This condition is recurrent and the necessity for future surgery as the only available remedy is amply indicated by the past course of treatment and the prognosis given. (Tr. 249)

Dr. Berg's report of examination is erroneously labeled as Plaintiff's Exhibit No. 25 starting at page 389 of the Transcript of Record whereas it is actually Defendant's Exhibit No. 25 (Tr. 104).

Also, Appellant's witness, Dr. Leonard, when questioned by the Court on the effect of osteomyelitis, said it results in sloughing of the bone, that sometimes frequent operations are necessary to keep ahead of it and that amputation of the limb may have to be considered. (Tr. 300, 301.)

CONCLUSION

The foregoing review of this case shows that the preponderance of the evidence supports the findings of the facts of the experienced trial judge. His opportunity to judge the credibility of the witnesses, to evaluate the testimony and to relate it to the exhibits in reaching his determination should be given the credence and effect intended by Rule 52A, Federal Rules of Civil Procedure. It should be noted that the cases selected by the appellant to justify its right to ask this court to overrule the findings of the trial judge are peculiar in nature in that they were equity procedures. *Sbicca-Del Mac, Inc., v. Milius Shoe Co.* (CCA 9), 145 F. 2d 389, 395, relied upon by appellant is a patent infringement suit. The court is well aware that in suits of this type where extrinsic evidence is not needed for the purpose of explanation or valuation and where a mere comparison of structures is sufficient to determine the issues, an exception to the usual effect given the trial court's findings exist. "Findings in the Light of the Recent Amendments." 8 F.R.D. 271 Yankwich, Leon R. showing patent cases are considered as an exception.

The cases cited by appellant are best answered by referring the court to the cases holding that it is not clearly erroneous under Rule 52A of the Federal Rules of Civil Procedure for the trial court to choose between two conflicting views as to the weight of the evidence. *Bjornson v. Alaska Steamship Co.* CA 9th, 193 F. 2nd 433; *City of*

Portland v. Luckenbach S. S. Co. CA 9th, 1955 A.M.C. 6, 10; *Carr v. Yokahoma Speicie Bank Ltd.* CA 9th, 200 F. 2nd 251.

There is substantial evidence, indeed evidence to which essentially there is no contradiction as to the fault of the appellant in this case and the burden of proof was carried and sustained both as to negligence and causation.

With regard to the burden of proof and the evidence to sustain it in an action for malpractice, the Oregon Supreme Court has said:

> "Consequently, the plaintiff in an action in malpractice has the burden of proving that the conduct of the defendant in his treatment of his patient did not measure up to the standard thus prescribed, but it does not follow that the proof must be in the words of any particular formula. If the medical witness testifies in substance to what amounts to a failure of the dentist to conform to the standard, that ought to be sufficient. The question, therefore, is whether an opinion of a qualified medical expert that a given treatment was not proper does, in substance, constitute evidence of such fault. We think it should be so held." Malila v. Meacham, 187 Or. 330, 336.

The evidence is overpowering that the appellant's physicians in Portland, both individually and collectively, failed to give Morin the proper, expected and required treatment and that Morin's disability, disfigurement, pain and suffering with the consequental financial and personal effects thereof, were the result of this "gross inattention".

Respectfully submitted,

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